Revista Bioética
Print version ISSN 1983-8042 | On-line version ISSN 1983-8034

Rev. Bioét. vol.30 no.2 Brasília Apr./Jun. 2022

Spirituality and religiosity in the approach to patients under palliative care

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Abstract

The development of the care plan for patients under palliative care must be unique and comprehensive, seeking to meet, as far as possible, the patient's needs. Within this plan, the spiritual and religious axis stands out. To analyze the importance of this type of approach, we carried out an integrative review study. The articles analyzed should answer the guiding question "what does the literature say about spirituality and religiosity in the approach to patients under palliative care?". The sample comprised 15 articles that show the multidisciplinary nature of the theme and point out the benefits of combining the spiritual and religious axis with care plans. We observed, however, that some practices and religious aspects can negatively influence the individual and the professional team feels unprepared to address and develop this issue with its patients.

Keywords: Palliative care. Spirituality. Religion. Humanization of assistance.

Resumo

Espiritualidade e religiosidade na abordagem a pacientes sob cuidados paliativos

A elaboração do plano assistencial para pacientes sob cuidados paliativos deve ser singular e abrangente, buscando suprir, na medida do possível, as necessidades do paciente. Dentro desse plano, destaca-se o eixo espiritual e religioso. Para analisar a importância desse tipo de abordagem, realizou-se estudo de revisão integrativa. Os artigos analisados deveriam responder à pergunta norteadora "o que versa a literatura acerca da espiritualidade e religiosidade na abordagem a pacientes sob cuidados paliativos?". A amostra foi composta por 15 artigos que evidenciam caráter multidisciplinar da temática e apontam os benefícios de aliar o eixo espiritual e religioso aos planos de cuidado. Observou-se, contudo, que algumas práticas e vertentes religiosas podem influenciar negativamente o indivíduo e a equipe profissional não se sente preparada para abordar e desenvolver essa temática com seus pacientes.

Palavras-chave: Cuidados paliativos. Espiritualidade. Religião. Humanização da assistência.

Resumen

Espiritualidad y religiosidad en la asistencia a pacientes en cuidados paliativos

El desarrollo del plan asistencial para los pacientes en cuidados paliativos debe ser único e integral, buscando satisfacer, en la medida de lo posible, las necesidades del paciente. En este plan destaca el eje espiritual y religioso. Para analizar la importancia de esta asistencia, se realizó un estudio de revisión integradora. Los artículos analizados trataron de responder a la pregunta orientadora "¿Cómo la literatura trata la espiritualidad y religiosidad en la asistencia a pacientes en cuidados paliativos?". La muestra constó de 15 artículos, que muestran el carácter multidisciplinario del tema y señalan los beneficios de la asociación del eje espiritual y religioso con los planes de atención. Se observó que algunas prácticas y vertientes religiosas pueden influir negativamente en el individuo y que el equipo profesional no se siente preparado para abordar y desarrollar este tema con sus pacientes.

Palabras clave: Cuidados paliativos. Espiritualidad. Religión. Humanización de la atención.

The authors declare no conflict of interest.

The World Health Organization [1] defines palliative care (PC) as an approach that seeks to improve the quality of life of patients and family members facing problems associated with life-threatening diseases. In the face of an irreversible prognosis, the care provided is no longer based on healing, but on preventing and relieving suffering, identifying early the efficient assessment and effective treatment of pain and other physical, psychosocial, and spiritual problems [2].

Considered as a transforming agent and emotion regulator, spirituality should be used as a therapeutic tool, constituting an essential strategy to improve the quality of life of patients experiencing a terminal illness process [3].

Spirituality determines an individual's opinions and attitudes, influencing their way of caring or selfcare [4]. Often seen as synonyms, spirituality and religiosity differ in their meanings. Spirituality refers to universal human needs and may or may not include specific religious beliefs, besides offering a philosophy or guide to an individual's choices. Religion, in turn, encompasses a group or belief system, involving concepts such as supernatural, sacred or divine, moral codes, practices, values, institutions, and rituals associated with such beliefs [5].

Exercising religiosity and spirituality stimulates neurotransmitters—stimulators of the cardiovascular, endocrine, and immunological system—, resulting in physiological and systemic reflexes. Through the sympathetic and parasympathetic nervous system, exercising spirituality can contribute to decrease heart rate, reduce cortisol production, and benefit the performance of the body's defense cells [5].

When facing the insecurity, doubts, and sorrows caused by the prospect of an incurable disease, faith can bring comfort and safety to patients and their loved ones, who find in religious or spiritual belief and practices the necessary support to cope with the situation [4]. Hence, understanding the spiritual and religious parameters of an individual is paramount.

As such, this study sought to analyze the scientific literature on the effects of spirituality and religiosity in palliative care patients.

Method

In Health, integrative review is a key methodology for developing evidence-based studies, allowing the analysis of experimental and non-experimental studies on a specific topic to understand the proposed topic, define concepts, review theories and evidence, and analyze methodological issues [6].

Starting from the research question "what says the literature about spirituality and religiosity in the approach to patients under palliative care?", we first stablished the effects of spirituality and religiosity on patients under palliative care as our problematic. Inclusion criteria consisted of papers published from 2009 to 2019 in Portuguese, available free of charge in the chosen databases, that addressed the problematic. Exclusion criteria comprised studies that discussed spirituality and religiosity in patients outside of palliative care, articles on palliative care that did not touch on spirituality and religiosity, theses, dissertations, and monographs.

Bibliographical search was performed in January, February, and March 2020, in the Virtual Health Library (VHL), LILACS and MEDLINE databases using the following Health Sciences Descriptors (DeCS), articulated by Boolean operator "*and*": "cuidados paliativos" [palliative care]; "espiritualidade e religião" [spirituality and religion]. The SciELO database was used to complement data collection.

The search returned 106 articles, 61 from LILACS, 34 from SciELO, and 11 from MEDLINE. After excluding duplicates and papers that did not meet the pre-established inclusion criteria or presented an approach other than the one being reviewed, the final sample included 15 articles, resulting in the exclusion of 91 articles.

Through the analytical, critical, and detailed reading of the selected articles, we extracted the results considered to be of greater relevance to characterize the scientific production on the topic. Next, a synoptic table containing title of the article, year of publication, journal, interventions, and conclusions was elaborated.

The *corpus* of analysis was defined by reading, grouping the articles according to content similarity and categorizing the data. The division by themes and related contents was complemented

by other studies on palliative care, spirituality, and religiosity. Based on the meaning nuclei highlighted in the articles, we divided our discussion into three categories: 1) the meaning of spirituality/religiosity for patients under palliative care; 2) physiological changes due to spiritual/religious approach in patients under palliative care; and 3) professionals' attention to spiritual/religious issues.

Results

Of the 15 articles selected and analyzed in this integrative review, five were published in 2016, three in 2017, two in 2014 and 2018, and three in 2009, 2011 and 2015. This indicates poor scientific production on the topic in Portuguese during the analyzed period, and absence of publications for the years 2010, 2012, 2013, and 2019, also included in the time frame.

Results point to a multidisciplinary approach to the problematic, demonstrated by the diversity of experts involved as authors, such as nurses, physicians, psychologists, among other health professionals. As for the methodology, ten studies were qualitative, one was quantitative, and five were reviews. Table 1 (Appendix) summarizes the articles included in this integrative review.

Discussion

After reading the selected articles and grouping the information, we defined three thematic categories: 1) the meaning of spirituality/religiosity for patients under palliative care; 2) physiological changes due to spiritual/religious approach in patients under PC; 3) professionals' attention to spiritual/religious issues.

The meaning of spirituality/religiosity for patients under palliative care

Concepts, questions, and perceptions concerning the finitude of life are inherent to the human being. When confronted with a diagnosis with no prospect of cure or reversal, patients face dilemmas related to their life project, mainly due to breakdown of emotional ties and doubts around death. These type of situations imply experiences different from those lived by individuals until they encountered this new reality [2-7].

As a result, individuals develop beliefs and convictions that provide them with a greater sense of security by exercising their spirituality/religiosity [8]. In many religions, dying is intertwined with a greater purpose, usually tied to some deity or superior being. Catholics and Protestants believe that life continues in a new plane, close to God, or in a place of pain and suffering. Religions such as Spiritism, Buddhism, Hinduism, and Taoism, preach reincarnation [9].

If mobilized, the spiritual and/or religious dimensions can help patients strengthen the feeling of hope, usually mediated by faith and belief, which subjectively determine how these individuals will behave regarding their state and treatment [10,11].

From this development, the disease and the imminence of death are seen in a new light, based on a purpose and meaning that can lead to personal maturation and a different stance before the situation, resulting in increased hope and a desire to continue living, even if the awareness of finitude remains [7-12].

Despite the positive results, this involvement is not without risks. Some beliefs preach the existence of punishment after death, usually associated with choices made during life [9], projecting on the patient a feeling of strong fear and increasing uncertainties about the death process.

Some religious practices have conceptions about the health-disease process that induce feelings of guilt and grief; others lead patients to wait for a miraculous cure, encouraging them to abandon care, projecting counterintuitive effects that could significantly affect the natural course of the disease [13].

Physiological changes due to spiritual/religious approach in patients under palliative care

Studies show that practices such as supplication, prayer, and meditation can help control anxiety and stress. Besides aiming at spiritual well-being, these practices result in physical benefits by reducing the rates of depression, despair, suicidal ideation, premature death wish, and hopelessness in terminally

ill patients [12]. Arrieira and collaborators [3] observed that spirituality is directly linked to giving meaning to suffering, so that suffering becomes bearable through religious practices.

Faced with stressful stimuli, the body releases cytokines, cortisol, adrenocorticotrophic hormone (ACTH), norepinephrine, and adrenaline through the hypothalamus-pituitary-adrenocortical axis [14]. This response provokes systemic reactions that have an impact on affect and behavior, such as limbic and cortical influences [15].

Pain-induced stress stimuli increases the production of ACHT secretion [16], which in turn increases adrenocortical secretion of cortisol. This directly impacts the immune system and reduces lymphocyte production and leukocytes interleukin-1 release, culminating in hyperthermia and vasodilation, blockage of the inflammatory response to allergic reactions, a marked decrease in eosinophils and lymphocytes in the blood, and an increase in erythrocytes [14-17].

As for influences on the limbic system, changes in the hypothalamus, hippocampus, and tonsils may occur [14]. Depending on the affected region and the associations involved, we may observe reactions of fear, revulsion, intense pain, among others [17].

According to Seybold [15], spiritual practices help in regulating mood in the face of pain through the increase of serotonergic receptors. The release of other mediators, such as dopamine and GABA, also contributes to reduce pain perception [12].

Professionals' attention to spiritual/religious issues

When a care plan is established considering the patient's individual characteristics, the patient-physician relationship improves significantly [18]. Such a bond can result in several benefits for both sides. When patients trust the professional or the team, they show greater adherence to the proposed practices. In turn, when professionals know the patient better, a more humanized approach is established [19].

Being at the forefront of patient care, nurses must be trained to discuss and address these issues. Developing their ability to interact with the various types of spiritual beliefs and values is imperative. Only then can a more comprehensive practice to meet the needs of patients undergoing treatment take place [5].

However, we must also consider the professional's own beliefs [8]. This aspect is fundamental to prevent interference during care and ensure neutrality, an indispensable prerequisite for good practice during care [5].

The care plans developed by the nursing team usually focus on technical actions that address the patients' physical needs, but not their psycho-socio-spiritual deficiencies [2-20]. In the face of an irreversible diagnosis, however, the entire axis of life is shaken, producing in the patients and their family changes and needs that need to be met [21].

In a study with patients about the support given by the nursing team regarding spirituality and religiosity, Crizel and collaborators [20] observed that health professionals neglect this approach, restricting it to sporadic visits by religious authorities [20].

Some professionals point to the lack of time to develop actions that can meet these needs, which are restricted to bathing or other bedside procedures, such as musical performance and Bible reading [22].

The lack of adequate professional preparation to deal with issues inherent to this axis of care is therefore noticeable [8]. In the absence of a practice that contemplates spiritual/religious needs, dysfunctionalities may occur that generate more doubts, uncertainties and insecurity to the patient or discomfort for the professional, who ends up distancing themself from this theme [23].

Such unpreparedness is intrinsic to professional education, since currently no curricular component addresses this issue. Few disciplines focus on this topic during graduation [24]. Professionals are thus forced to seek complementary courses and training to develop skills in religiosity/spirituality [25].

Including spiritual and religious issues in the care plan requires creating a careful anamnesis process, so that identifying the particularities of each belief, such as convictions about the finitude of life, types of religious ties, rites, promises, sacraments, or obligations is possible [5-26]. According to Guerreiro [27], nursing professionals need to develop active listening skills, as well as verbal and nonverbal language to discern the best way and time to intervene in these issues.

Final considerations

Spirituality strengthens the individuality of the human being. Given its vastness and sensitivity, the topic must be addressed responsibly. A good understanding of this theme can help professionals and provide more effective care for patients under palliative care. Despite the positive effects of spirituality and religiosity in PC patients, this dimension has yet to be properly explored in care plans.

This type of care must be provided by trained and qualified professionals, to establish a unified conduct for the scientific regard that this topic requires. Since the absence of this curricular component is cited as the main impediment to the approach, specific training should be provided and promoted during academic education.

Despite their unpreparedness, some professionals, empathically and empirically, try to incorporate these practices into their routines through small actions. But despite the good intentions, the risk of harming the therapeutic and emotional state of patients is still great.

The articles analyzed show how much the spiritual and religious dimensions have been neglected in the scope of care provided to PC patients. An anamnesis contemplating these aspects can benefit both patient acre and the patient-physician bond.

Thus, despite its relevance and the growing number of studies published in recent years, the topic of spirituality and religiosity shows gaps that need to be explored. A underreported aspect refers to the negative effects of religious approaches. Moreover, knowledge and use of assessment methods on the subject are scarce. This aspect should also be considered, since it relates to the acquisition of more appropriate tools for professional management of the various religions and beliefs.

This article was elaborated from Jonatas Caetite Santos' end-of-course research in nursing, developed under the supervision of Adriana da Silva Sena and Jelber Manzoli dos Anjos.

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Research

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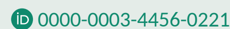
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Jonatas Caetite Santos wrote the manuscript and was responsible for the necessary corrections and adjustments. Adriana da Silva Sena supervised the discussions and final considerations. Jelber Manzoli dos Anjos collaborated in the general revision of the manuscript.

Received: 3.17.2021
Revised: 5.3.2022
Approved: 5.16.2022

http://dx.doi.org/10.1590/1983-80422022302534EN